

The Art of Evidence-Based Practice

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The purpose of this article is to discuss evidence-based practice (EBP) from the perspective of a self-identified evidence-based practitioner. Discussion of EBP includes choosing an initial intervention and evaluation procedures, the iterative process of rechoosing and refining an intervention over the treatment life span, and the importance of evidence within the specific clinical situation. Two illustrative case studies are presented. Practice principles include (a) explaining EBP clearly, including an ability to deconstruct key elements; (b) creating an evaluation that yields useful outcome data for practitioner and client and is realistic given the characteristics of the client system; (c) refining intervention and evaluation efforts, based on increased knowledge of the client system and as their willingness to participate changes; and (d) understanding relevant evidence about specific techniques, incorporating evidence developed as part of the intervention, and being critical consumers of both types of evidence in specific situations with clients and client systems.

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Evidence-based practice (EBP) represents an important trend in social work education (Howard, Bricout, Edmond, Elze, & Jenson, 2003; Howard, McMillen, & Pollio, 2003). The idea of educating social workers to be consumers of the research literature, use systematic approaches to increase their practice effectiveness (Rosen, 1993, 2003; Rosen, Proctor, & Staudt, 1999), and continuously evaluate their own practice outcomes has captured a portion of the education community, to the point of incorporation of this agenda as a “new paradigm of education” (Howard, McMillen, et al., 2003). This trend in social work reflects a larger and multidisciplinary trend across other clinical professions, such as medicine and clinical psychology (Thyer, 2003).

As much as this trend has been greeted with enthusiasm by members of the social work education and research community, it has been greeted by what Zayas and colleagues (Zayas, Gonzalez, & Hanson, 2003) archly characterize as “lower-than-anticipated enthusiasm of practitioners” (p. 63). Sheldon (2001) in a cogent comment attributed this reluctance to the idea that EBP methods are thought by practitioners “likely to cramp the

natural style of staff, and therefore, will lead to more harm than good” (p. 801). Yet it is clear that when practitioners are in the position of clients, they prefer providers to be practicing from best evidence (Pollio, 2002; Sheldon, 2001). In fact, Gambrill and Gibbs (2002) found that social workers would hold their own medical doctors to higher standards of evidence than they hold their own practice.

While most attempts to explicate EBP training and practice can feasibly be followed by practitioners, they are limited in that they still represent researchers and academicians speaking to practitioners, rather a true dialogue between academics and clinicians. Furthermore, there is still somewhat of a “top-down” feel to these efforts—academics are explaining how EBP can be incorporated generically into practice. Clinicians reading this piece are probably experiencing a familiar skepticism—namely, that EBP does not provide direction on actions within the clinical process. Answering the question posed by Zayas et al. (2003) “What do I do now?” not only for teaching EBP but also for implementing it within the therapeutic relationship is a critical next step in the discussion of EBP in clinical situations (Mattaini, 2003). This is the task of the current piece.

The genesis of what follows comes from insights gained through my own struggles and frustrations implementing EBP into a clinical practice. At this point, this article moves from a generic consideration of EBP to a more personal one. Accordingly, the voice of the article changes from third to first person.

It became clear to me over time, that my own writing on EBP had only limited utility in my day-to-day work

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with the children, adolescents, and families that I saw initially in my practice in an inner-city mental health agency and most recently in my own private practice. I found myself repeatedly tempted to give up espousing EBP and follow my experience as a long-time practitioner—validating the reluctance expressed by other clinicians. This frustration was further compounded by my repeated inability to answer students in my practice class who wanted to know how EBP would respond to the vignettes and role-plays with which they were presented, other than some variant of “it depends on a lot of different variables.”

As I reflect on this disconnect between my experience as an academician-researcher and as a practitioner, in the context of the above-reported observations about the reluctance of practitioners to embrace EBP, I have come to the realization that part of the problem results from conceptualizing practice “success” in two fundamentally different ways. The clinician focuses on the process within and across the intervention, providing the best possible context for individual change. In our clinical supervision, we talk about evaluating our own skills and increasing the likelihood that the client can achieve change. Thus, the metric of “success” to a clinician is becoming skilled in the “art” of clinical practice. Repeatedly, we caution our students and supervisees (and ourselves) that focusing on outcomes will lead to frustration and burnout.

This focus is diametrically opposed to the fundamental tenet of EBP—that “success” is measured through client change. This forces the practitioner into a double bind. We work with persons who are often resistant to change, yet our success—measured through the “science” of practice—is based on achieving outcomes, which contradicts our own training on how to assess our practice. Furthermore, EBP tends to conceptualize the therapy in a linear manner. The client comes in, is assessed and the goals established, an intervention occurs, and the client achieves the desired outcome. Any good clinician is aware that therapy is anything but linear in nature. Goals are modified or adapted, new goals are chosen, each responsive to the individual client’s need as it changes over the span of the intervention.

This article works to endeavor to integrate the “art” of practice and “science” of EBP. I will take what I have learned in implementing EBP into my own practice and reflecting on my personal vision of what EBP looks like within the clinical session. In one sense, it represents a dialogue between the part of me that advocates teaching EBP and the part that has experienced directly the objections raised by practitioners struggling to implement (or

deciding against implementing) EBP as part of clinical practice.

EBP AND THE EB PRACTITIONER: BEGIN DEFINITIONS AND CONSTRUCTS

To launch this integration, it is necessary to begin by establishing an initial construct of EBP. The definition used here follows many others in defining *EBP* as the conscientious and judicious use of current best practice in making decisions for individual treatment (Howard, McMillen, et al., 2003; Pollio, 2002; Sackett, Richardson, Rosenberg, & Haynes, 1997). It departs somewhat from standard definitions of EBP in that it conceptualizes evidence as any systematically collected information relevant to informing practice. Thus, evidence includes quantitative data, such as randomized clinical trials, and also qualitative methods (such as narratives, case studies, and focus groups). This definition further includes data collected by the practitioner, single-system design, and critical analysis of personal practice experience (Pollio, 2002). From this definition, practitioners using EBP are not constrained to follow only available evidence but to develop their own evidence to focus it on their unique practice. As I have argued previously (Pollio, 2002), this puts an onus on the practitioner to be able to articulate the evidence used in making the practice decision.

One consistent objection to using evidence to guide training and clinical practice is the lack of sufficient research to consistently guide practice decisions (Frost, 2002; Proctor & Rosen, 2003; Reid & Fortune, 2003). This argument has somewhat of a “straw man” quality, for two reasons. First, in some clinical areas, evidence clearly exists to adequately inform training (e.g., in group work: Pollio, 2002). Second, the intent of EBP is not just to familiarize students and practitioners with effective models but also to critically consume EBP as part of the intervention process (Howard, McMillen, et al., 2003). Zayas et al. (2003) presented a conceptualization that does an elegant job of describing the task of educating social workers to EBP. They argued that the task of teaching EBP is not just instructing them on available evidence but also focusing on creating EB thinking. Social workers are not just consumers of EBP but also need to be trained in critical thinking as a primary tool in translating evidence into practice (Gambrill, 2000, 2003). The idea of EB thinking, as opposed to EBP, provides the clinician and consumer with a much more flexible tool—one that moves beyond simply implementing effective interventions.

Thus, in conceptualizing EBP, it is necessary to understand that I am not talking strictly about evidence around interventions but also on factors within the session. The assumption that EBP is based on interventions overly simplifies the meaning of evidence and, consequently, limits its utility for practitioners. In terms of group work, a substantial body of evidence exists for understanding group dynamics and group techniques (Pollio, 2002). Evidence-based practice with groups clearly includes research on constructs and behaviors within the session. Evidence-based practice also includes information on issues such as treatment dose and intensity.

In discussing EBP within the clinical process, I should acknowledge the considerable influence of the systematic planned practice model (Rosen, 1993, 2003; Rosen et al., 1999), which begins with the idea of the practitioner as using a replicable and consistent approach to collecting information, identifying interventions, implementing, and evaluating outcomes. In some ways, the clinical practice discussed here follows these key elements of this model. My experience has been that this approach creates opportunities for implementing evidence into practice and building single-system design into the evaluation process.

However, as a clinician, I have found that models, even Rosen's elegant one, lack an ability to respond to what I'll term here—for lack of a better descriptor—the *messiness* of real-world practice. By this term, I am moving beyond the critique that available evidence has limited application with most clients, and also including the idea that clients and systems are rarely static in their needs and desires from the therapeutic experience. I am sure that clinicians reading this discussion will share the frustration of conducting a reasonable well-structured and complete assessment, identifying a problem for work, implementing a plan based on available evidence, and then having to repeat the process again almost immediately based on changes within the client, his or her ecology, managed care systems, organizations, or random acts of chance.

One means to elaborating on the concept of practice "messiness" is to contrast positivistic approaches to evidence with the complex unique individual needs of the client. Positivistic science is, by definition, reductionistic in nature. The point of positivism is to understand phenomena in a way that generalizes across samples or populations. Working with clients, on the other hand, consists of understanding individual behaviors, then working to change them using interventions and clinical relationships. In one sense, positivistic approaches have utility to the extent to which the individual matches the population studied.

This tension can best be understood in what I will term a *deconstruction-reconstruction* approach. The practitioner begins with available evidence and assesses it for its utility with the current client system. The key part of assessing the utility of the potential EBP is deconstructing the evidence based on the individual client. This would consist of being able to understand and articulate the intersection between the evidence and the individual (or family or group). If we are discussing an intervention, this might consist of an awareness of the strength of evidence, whether the intervention has been tested for efficacy or effectiveness, and whether there has been any evidence of the intervention's effectiveness with the unique characteristics of the client system. This would entail deconstructing the evidence to the individual client system.

Reconstruction would then consist of implementation of the EBP with the client system. In partnership with the client system, the practitioner discusses the evidence (at a level appropriate for the client), and together they decide on how to implement EBP. Thus, the evidence is deconstructed by the clinician based on EB thinking and reconstructed through the clinical interaction into the approach with the individual client.

In concluding this discussion of the concept of deconstruction-reconstruction, I would be remiss to focus solely on the way that this approach has utility in developing interventions with clients. An ecological approach would suggest that part of the messiness of clinical practice has its origins in the changes within the client-clinician relationship and the inherent instability of all lives. Thus, the deconstruction and reconstruction change over the lifespan of the intervention, indeed within each clinical interaction. The question facing the clinician is not only "How can I convince the client to follow the best practice?" but also "How does evidence inform my behavior within the session and/or situation?" and "How has the process of this intervention changed the EBP that was previously agreed on?" Answering these questions requires a discussion of EBP within the treatment process.

EBP IN THE TREATMENT PROCESS

This section illustrates different issues that arise in implementing EBP within clinical interventions. It begins with an examination of choosing an initial intervention and evaluation procedures, discusses the iterative process of rechoosing and refining an intervention over the treatment life span, and highlights the importance of

evidence within the specific clinical situation. It is not the intent here to discuss the evidence on specific intervention models but rather to consider the process by which these kinds of issues play out in clinical practice. Thus, practitioners and academics are free to insert their favorite intervention in following along with this discussion.

Choosing Intervention and Evaluation

The first issue, and perhaps the one best discussed in the literature (Zayas et al., 2003), is the choice of EBP intervention and evaluation that occurs as part of the initial phase of practice. As any social work student could explain, the beginning phase of an intervention includes exploration, assessment, and treatment planning. In terms of EBP, this includes identification of the problem for work, matching with available best practices, developing an evaluation method, and contracting for implementation of treatment. Although I concur with Zayas et al. (2003) that this particular phase of intervention relative to EBP has been relatively well explicated, there are a couple of facets that have recurred sufficiently frequently within my own practice to warrant further attention.

Frequently, clients report negative experiences with previous implementations of specific EBP. Unfortunately, the client's implementation of these interventions often contains flaws of such magnitude as to make it appear likely that these issues caused the lack of success, rather than the model itself being inappropriate or ineffective (whether this comes from the client's being unable to implement appropriately or the previous clinician's not understanding or describing the intervention is unclear). When these EBPs are perceived as ineffective, families are understandably reluctant to try them again. Thus, it becomes my responsibility to discuss the EBP, deconstructing it to help the client to understand the form of the practice as it might be correctly implemented as I advocate for its implementation.

A second facet of EBP in the beginning phase of treatment worth further attention is the creation of evaluation methods to assess treatment gains and guide further intervention efforts. Although my general approach follows conventional wisdom in being based in single system methods, it has been my experience that my clients generally have limited willingness and/or ability to implement sophisticated data collection methods. This is not to state, however, that clients have limited willingness or ability to collect useful information. An example of this comes from a frequent clinical situation in my own practice. Families will often bring children to me to help me "fix" their child. Often, this consists of operationalizing what

the family means by this term, identifying a targeted behavior, and discussing how we might conceptualize success. Furthermore, the onus is on me to explain how we will use this information to guide the treatment process. Returning to the situation where families have "already tried that intervention," a further reason for resistance is the experience of the evaluation being too complex (or too simplistic) to allow the families to identify the success of the intervention in its early phases.

For example, when the behavior for change is a temper tantrum, families are generally willing initially to note the time and date of the event, give a rating of intensity, and note the duration of the event. One way that this willingness is fostered is to point out that this information will allow us to examine the possibility of patterns of behavior that yield simple solutions. Because this has been the case on several occasions (e.g., when tantrums occur consistently prior to a late-night bedtime), this provides a compelling argument for this type of data collection. With this information, we can then reconstruct the events within the therapeutic session, thus adding to the complexity (and utility) of the available data. The point of this example is that the successful implementation of evaluation methods does not require burdensome data collection that is unlikely to yield compliance, rather a good understanding of the methods and purpose of evaluation, and the ability to articulate a compelling rationale for the client's participation.

Rechoosing or Refining the EBP

This discussion leads directly into another issue in implementing EBP in real-world practice. Clients are often unwilling in the initial phase of treatment to participate in complex treatment protocols created as part of EB interventions. Often, my experience has been that clients are unwilling to completely depart from their previous approaches to the problems that brought them to treatment. In addition, because the initial treatment planning generally occurs prior to collection of useful data (as with many clinicians, my practice setting is reimbursed through a capitated system, which does not allow the luxury of multiple sessions prior to a treatment plan), the choice of an initial intervention is aimed more generically than deconstructed to the unique client system.

This leads to the important requirement by EB clinicians to view the intervention and evaluations as developing over the life span of the treatment. Interventions and evaluations can be increased in sophistication as the relationship progresses. New interventions can be substituted based on a deeper understanding of the client system or

(as is often the case) new problems for work emerge, or even as first intervention efforts are shown to be ineffectual. Similarly, evaluations can be modified based on initial data collection, increased willingness of the family to participate in data collection, or as first data collection efforts are shown to yield poor information. Thus, clinicians need to be willing to rechoose or refine interventions with the client system over the life span of the treatment.

This returns to the deconstruction-reconstruction construct discussed previously. Rather than viewing this process as something that focuses on the initial phase of treatment, it might better be thought of as an iterative process. As the work progresses, the knowledge of what are essential deconstructive elements increase, and the ability to mutually reconstruct into effective individual-level interventions similarly intensifies. To go back to the evaluation example, as we discuss the specific temper tantrums, families often become frustrated with the limited information provided in the initial data collection methods. Families have frequently decided that they need to write a description of the events triggering the tantrum and to document what worked and what did not. In many situations, where there has been initial resistance, the child and family will want to examine the results graphically, charting changes over time. Where the child is somewhat older, it has been the case on multiple occasions, where the child wants input on what gets written down as data, or even insists on collecting separate data.

EBP in the Specific Clinical Situation

Another EBP-relevant issue that affects on the rechoosing and refining of specific interventions is the use of evidence within the specific situation. This issue plays out along two dimensions. The first one is the use of specific techniques within specific situations. In one sense, this discussion follows what students are taught in practice courses—that clinicians need to use their professional selves within the clinical situation. What is new here is that this use of self should be guided by evidence about specific techniques. As I have discussed extensively elsewhere (Pollio, 2002), this includes being aware of the evidence (albeit somewhat slim outside of group dynamics) linked to use of specific techniques.

The second dimension continues the concept that EBP consists of collecting evidence specific to the family with the idea that clinicians need to be critical users of EBP; that is, clinicians need to be willing to combine the existing evidence from the literature with their own analysis of the dynamics of the situation to guide specific responses

and strategies to situations. This is perhaps the clearest example of the “art” of EBP. Because the decision of how to approach specific situations varies along multiple dimensions, clinicians must choose to respond based on their own assessment of the situation. In this case, EBP provides multiple tools to inform responses; however, the ability of the clinician to synthesize this information remains critical to the success.

THE ART OF EBP

To illustrate the way the concepts discussed work in real-world settings, this section presents two case studies of the art of EBP from my clinical practice. The first case focuses on the use of evidence in the assessment phase of practice, the second presents an intervention developed as part of my practice and its refinement in family treatment. Readers should be aware that details of this case material have been altered to protect the client’s confidentiality. Furthermore, the details of the intervention process have been simplified to clarify the narrative process.

Clinical Case 1: EBP in the Assessment Phase

The client was a female 12-year-old. She was an only child, with a single mother employed in a health setting as an aide. Two assessments (one by myself and one by a psychiatrist) yielded a complex clinical picture. Using standardized instruments from multiple sources, the psychiatrist and myself posited initial diagnoses of major depression and attention deficit disorder, inattentive type. In addition, my assessment identified unresolved trauma around the death 2 years prior of her estranged father. The assessment yielded three possible areas for clinical focus—one each relevant to the presenting diagnoses, and the third around issues of grieving. Perhaps more important for this discussion, each problem-for-work required a somewhat different clinical focus. Furthermore, the choice of initial focus led to different possible EBP based on the problem specified.

At the next session, I began by sharing the evidence collected as part of the assessment process with the mother and daughter. We reviewed the data collected, explaining both the scores on the standardized assessment and how they might be interpreted. Next, we went over the preliminary diagnoses, discussing how certain symptoms interpreted in different ways led to each of the possible diagnoses and focus. The feedback of the mother and daughter was used to help clarify the clinical picture. Unfortunately (and this is often the case in my experience),

the feedback validated the importance of all of the presenting material. Because the review of the assessment did not yield a clear direction for intervention, the next step was to review the different ways we might integrate the issues and discuss EBP options based on each construct. The mother identified one of the choices as something that had been tried before but felt had not worked. Among the remaining choices, the mother identified an intervention that she thought might make sense, whereas the daughter identified another.

Prior to choosing which intervention to attempt, we next discussed what the outcomes of the intervention might be. As part of our discussion of how we might evaluate change, it became clear that there was considerable agreement between mother and daughter as to what change was desired. This led us back to a discussion of the intervention possibilities and eventually led to a plan for treatment focusing on the depression. A further conclusion of this process was the decision by the daughter to include medication and therapy in her own treatment.

This vignette demonstrates a number of issues related to translating EBP into real-world practice. The assessment yielded multiple potential targets for interventions based on the construction of the problem for work. These problems were identified using standardized assessment tools, thus each had reasonable validity and reliability. Unusual to EBP, each of the identified problems had some reasonable options for implementing EBP. Furthermore, the family's negative previous experience with one of the EBP constrained the potential choice.

Understanding and resolving these issues demonstrated one possible application of the "art" of EBP. Rather than relying on the evidence itself, I chose to include the mother and daughter in the treatment choices. When this still did not yield a clear answer to the focus for work, the development of the evaluation methods allowed us to identify that both of the two wanted to change the same behavior. This use of evaluation as part of developing the initial plan for work demonstrates the possibility for incorporating evaluation as part of the development of individualized EB interventions.

Clinical Case 2: Developing and Refining a Homegrown EBP

This vignette focuses on a family, consisting of a mother and two teenage children, a girl age 15 years and a boy age 13 years. The mother had brought the family in because the fighting between the two siblings was consistent and often included physical confrontations. Although there was consensus across the family system

that the fighting was the issue for work, the mother wanted "the kids to stop fighting," and each sibling wanted the other to stop "bugging" him or her.

The initial intervention was one that I had developed and tested using single system design across multiple family therapies. Based in behavioral principles, this was what I called my "refrigerator intervention." It consisted of the mother and children's developing a list of household tasks that required doing periodically, needed at least 15 minutes to perform adequately, and could be completed by two people working together. This list was then placed on the refrigerator—hence the name. The intervention was based on the presented logic that the children fighting was taking away from the family's ability to live pleasantly, so the consequence would be that when the children fought, they would have to give back to the family by completing a household chore cooperatively. When the children fought, the mother would get to choose a task from the refrigerator, which the children would then complete together. Completion of the task successfully ended the consequence, and the situation was then concluded. If the children continued to fight during the task, another task was chosen, and the protocol repeated. Regardless of the cause of the argument, both children received the same consequences.

Part of the reasoning behind this intervention was that it was reinforcing to all participants. The mother would get a household task done, and the children could be reinforced for working cooperatively. Furthermore, all members of the family were able to see the humor in the intervention. Evaluation was simple; each week we would examine the dynamics of the fight for each task that the children completed. All agreed with varying levels of enthusiasm.

Over the next month, we documented a decrease in the number of refrigerator activities and an increase in the children's ability to complete these tasks successfully. As a positive side effect, the house was reported to be exceptionally clean. After the 1st month, the mother reported that she wanted to add a new goal on each child's completing schoolwork. In discussing what possibilities existed for intervention, the family all indicated that they wanted to continue the refrigerator intervention, adding two lists—one for each child—that would be completed if the child did not complete his or her homework on time. The children agreed, and each indicated that they would find it funny if the other "went to the refrigerator."

This vignette illustrates the potential for refining and implementing EBP based on the specific clinical experience. In this case, all members of the family experienced the intervention as positive and were impressed at the

evidence collected in the session—as well as the positive benefit of a clean living environment. Rather than choose a new intervention, they were willing to refine the existing one based on the evidence. The refining of the intervention was based on the family's increasing willingness to participate and the variety of available proof.

The case further illustrates the potential for EBP to be adapted based on the individual experience. Moving from a generic intervention (in this case, one developed by myself using single system design), we were able to focus it in on the specific family. Furthermore, the inherent humor in the intervention was used to motivate the children to participate. Thus, the intervention not only was adapted but also was changed based on the clinician's ability to enter in with the family into the potential for humor.

PRACTICE PRINCIPLES FOR THE ART OF EBP

In concluding this discussion, it is important to end by looking at how the ideas and case material here yield practice-relevant information. Rather than returning to education or academia, it is my hope that the principles described will be useful to practitioners. Only as a secondary concern are these intended to guide training. Based on the discussion, I propose the following principles for implementing EBP into practice. EBP-based practitioners need to

- be able to explain the EBP clearly, including an ability to deconstruct key elements as a corrective experience to previous failed implementation efforts.
- be able to create an evaluation that yields useful outcome data for the practitioner and the client and that is realistic given the characteristics of the client system.
- be able to rechoose and refine intervention and evaluation efforts, based on increased knowledge of the client system and as their willingness to participate changes.
- be aware of relevant evidence about specific techniques, incorporate evidence developed as part of the intervention, and be critical consumers of both types of evidence in specific situations with clients and client systems.

The first of these principles reflects the synthesis of the ability in the practitioner to not only use EB thinking but also to be able to articulate what are the key features at a level clear to the client system. This suggests a deeper understanding of the key elements to EBP, including the evidence supporting the model, its applicability, and key elements required to maintain the effectiveness of the intervention. Furthermore, the practitioner needs to be able to connect the EBP to the client's experience, under-

standing his or her reluctance or enthusiasm and being willing to respond to these effectively.

The second principle is similar to the first in that it involves the ability to understand evaluation methods and choices at a sufficient level of sophistication to explain the purpose of the intervention to the client system and to negotiate a plan that can be implemented. Furthermore, it requires an ability to identify targeted outcomes appropriate to the goal and to understand what information is necessary. This distinction between clinically essential evaluation and the most rigorous research methods represents the difference between using evaluation clinically and conducting research for academia. For example, the refrigerator intervention was not developed using rigorous research methods but also based on available theory combined with evaluation in similar clinical situations.

The third principle also requires the ability to implement EB thinking, this time over the life span of the intervention. Practitioners coming from an EB perspective have the advantage of using their understanding of existing evidence and interventions combined with their unique knowledge of the family to increase the potential for success within the individual intervention. Furthermore, it allows practitioners to change directions in practice if the initial efforts using EBP have proven ineffective.

The final principle emerges from the deconstruction-reconstruction approach discussed previously. As a critical consumer of evidence, the practitioner can break down evidence related to interventions; knowledge of evidence related to individual-level characteristics, such as race, gender, or sexual orientation; and insight from the collaborative relationship with the client systems. The practitioner weighs these factors, and—in collaboration with the client system—makes choices informed by evidence. Furthermore, the practitioner can take advantage of evidence on the utility of specific clinical techniques to drive her or his approach to the development of effective interventions.

These principles do not represent the only possible options available to clinicians seeking to incorporate evidence into their own practice. Nor is it meant to argue against the potential for implementing manualized interventions or treatment protocols where appropriate. Rather, it seeks to advance thinking about translation of EBP into real-world settings by appreciating the complexities inherent in every clinical relationship and even within each interaction. For EBP to become useful on an everyday basis with practitioners, experiences by clinicians seeking to implement EBP in real-world settings requires dialogue between clinicians struggling

to implement the EBP, researchers seeking to develop new ones, and academics seeking to communicate the methods to future generations of social workers.

EBP, RESEARCH, AND EDUCATION

In concluding this piece, I think it important to not just present on the art of EBP from a practice perspective but also to communicate from an EB practitioner to researchers and educators seeking to train present and future clinicians. It is essential that the development of evidence to inform practice include a clear conceptualization of its utility at the onset. Most important, researchers need to incorporate a clear understanding of the “real-world messiness” into their inquiries from the beginning. Incorporation of the “real world” does not just mean asking specific questions about mediating and moderating processes but also considering the standpoint of those potentially affected by the research to participate in conceptualizing it. Perhaps the simplest solution is to include the clinician and members of the population being studied in developing the research. Another alternative might be to partner with the various stakeholder groups across the research process—development, implementation and data collection, and interpretation of findings. Minimally, researchers need to utilize expertise of stakeholders in informing dissemination efforts.

For the educator, the discussion here highlights my belief that training for EBP is not fully conceptualized. Although there are multiple discussions for implementing EB practice in training (cf. Howard, McMillen, et al., 2003), no clear model exists for teaching concepts such as EB thinking. Furthermore, with few exceptions, educators are conceptualizing EBP training by focusing on helping practitioners develop research skills—such as reading evidence in the literature or developing single system research designs. The ability to understand evidence around within-session phenomena and for clinical constructs (such as process or engagement) requires further elaboration.

Activities that seek to develop “facts” are necessarily reductionistic in nature. Research and education aimed at informing practice are necessarily limited to what can be either verified or communicated in a limited period of time. Thus, from the perspective of EBP, both of these endeavors are necessarily oriented toward what I have labeled the “science” of EBP. Creating the context for change is necessarily contextual in nature. Thus, EB practitioners must focus on translating evidence into each unique client system, relationship, and even interaction—

what I have labeled the “art” of EBP. Understanding the perspective of all groups represents the next task in turning EBP into a viable paradigm for practice.

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